Report on the Outcome of the Integrated Inspection of Safeguarding and Looked After Children's Services in Middlesbrough

Date of Inspection	**6th June 2011 – 17th June 2011**
Date of final Report	**22nd July 2011**
Commissioning PCT	**Middlesbrough PCT (NHS North Tees)**
CQC Inspector name	**Lea Pickerill**
Provider Services Included:	**South Tees Hospitals NHS Foundation Trust** **Tees, Esk & Wear Valley NHS Foundation Trust**
CQC Region	**North East**
CQC Regional Director	**Jo Dent**

This report relates to the recent integrated inspection of safeguarding and services for looked after children which took place in the above Authority recently

It provides more detailed evidence and feedback on the findings from the Care Quality Commission's (CQC) component of the inspection, and links these to the outcomes requirements as set out in the Essential Standards for Quality and Safety.

Thank you for your contribution to the inspection and for accommodating the requests for interviews and focus groups with your staff and those of partner agencies at relatively short notice.

The team provided feedback to your local Director of Children's Services at the end of fieldwork and the joint inspection report to the authority is now published on the Ofsted website and can be accessed via this link: The joint inspection report.

Middlesbrough County Council	
Safeguarding Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of the safeguarding services	Adequate
Capacity for improvement	Good
Contribution of health agencies to keeping children and young people safe	Adequate
Looked After children Inspection Outcome	**Aggregated inspection finding**
Overall effectiveness of services for looked after children and young people	Adequate
Capacity for improvement of the council and its partners	Adequate
Being Healthy	Adequate

This report includes findings from the overall inspection report, and provides greater detail about what we found, mapped where relevant to the Essential Standards, in order that your organisation can consider and act upon the specific issues raised.

A copy of this report is being sent to your commissioning PCT, and CQC Regional Director. This report is also being copied to the Strategic Health Authority/Monitor as appropriate and CQC's head of national Inspections, who has overall responsibility for this inspection programme.

The Inspection Process

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of looked after children within a specific local authority. The two-week inspection process comprises a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributes to the overall framework for the integrated inspection.

CQC contributes to the inspection team and assesses the contribution of health services to safeguarding and the care of Looked after children relating to that authority. Our findings from the inspection contribute to the joint report published by Ofsted and also enrich the information we use to assess providers against the Essential Standards of Quality and Safety. This report sets out specifically the evidence we obtained in relation to these standards and extracts from the published report are included and identified.

CQC used a range of documentary evidence in advance of and during this inspection, and interviewed individuals and focus groups of selected staff and, where possible, children and young people, their parents and carers in order to provide a robust basis for the findings and recommendations.

This document sets out the findings in relation to the organisations listed above, but includes some areas which apply to one or more other NHS bodies where pertinent.

Context:

There are 33,480 children and young people aged 0-19 years living in Middlesbrough, according to the 2009 mid-year population estimate. This accounts for 24% of the borough's total population of 140,500. The number of children aged 5–14 years has decreased by 16% since 2001 but there has been an increase of 12% in the number of children aged under five. The 2010 Indices of Multiple Deprivation ranked Middlesbrough as the eighth most deprived local authority area in England. (Ofsted 2011)

Middlesbrough's Children and Young People's Trust Board (CYPT) is chaired by the lead member for children's services and comprises representatives from the council, health services, the Police, and the voluntary and community sector. A Children's Trust Executive, chaired by the Director of Children's Services, supports the work of the CYPT, overseeing the transformation work taking place across children's services. (Ofsted 2011)

NHS Tees commission all health services for Middlesbrough. Middlesbrough and Redcar and Cleveland Community Services has recently transferred to the South Tees Hospitals NHS Foundation Trust, which now provides all local community services, including health visiting, school nursing, physiotherapy, occupational therapy, child and school health administration, the dedicated looked after children's nurse, speech and language therapy and the James Cook University Hospital which is the main hospital facility. The Tees, Esk and Wear Valley NHS Foundation Trust is the mental health trust that delivers a range of tier three and four child and adolescent mental health services (CAMHS). (Ofsted 2011)

1 General – leadership and management

1.1 The local authority and PCT have identified the need for a collaborative approach to the commissioning of emotional health and wellbeing services across the partnership in Middlesbrough. This approach has been endorsed by the Children's Trust and there is a multi agency meeting taking place to take this forward.

1.2 The local director of public health for Middlesbrough is a jointly funded post between the primary care trust and the local authority. The local director for public health is also the public health lead for looked after children.

2 Outcome 1 Involving Users

2.1 Looked after children and young people are involved in the service design and delivery of the looked after child health service. Previous actions include the provision of a health promotion room where a young person could visit and discuss health relates issues. Young people are always asked to choose the venue for their annual health reviews. The Children in Care Council are designing the content and style of the soon to be launched health passport for care leavers.

2.2 There has been good involvement of young people in the development of services to minimise risk taking behaviours of children and young people in Middlesbrough. The risk reduction model has been heavily influenced by the outcome of consultation with young people who have been involved in all stages of design and delivery, including the production of promotional materials. Young people are involved in the application for the "You're Welcome" accreditation and there are plans for mystery shopping across the services provided under the risk reduction model.

3 Outcome 4 Care and welfare of people who use services

3.1 Good arrangements are in place to help safeguard children and young people that attend the A&E department at James Cook University Hospital, South Tees Hospitals NHS Foundation Trust. A computerised casualty card is generated for each attendance that includes details around previous attendances at A&E and whether a child has a child protection plan in place or if they are looked after by Middlesbrough LA. Children and young people either follow the "See and Treat" pathway where they are assessed by a senior medical clinician or they are seen in the main A&E department. Clinicians use the NICE guidance 'When to suspect child maltreatment' and a Quick reference guide is available within all treatment areas of the department. A stamp stating 'NAI considered' is used. However, on the "See and Treat" pathway, the stamp was not used as the notes are typed after the child has left the department. The A&E receptionist copies and sends a full record of the visit to the child's GP and health visitor if they are under 5, if they are over 5, then a discharge summary is sent to the GP and school nurse. A senior medical clinician reviews all attendances of children under 5 to check that appropriate action has been taken. Health visitors and school nurses confirmed that they routinely receive notifications from A&E around the attendance of any child under 18.

3.2 Good arrangements are in place to safeguard children and young people at the walk in centre at Ormebsy. Staff identify children and young people who repeatedly attend for treatment and there are good communication links to notify GPs, health visitors and school nurses of their attendance. The NICE Guidance for assessing children under 5 for non accidental injury are part of the initial assessment for treatment and there is ready access to the local child protection policies and procedures. Staff at the walk in centre are employed by the South Tees Hospitals NHS FT and have received their mandatory safeguarding children training.

3.3 Good arrangements are in place for the health visiting and school nursing teams to deliver the full healthy child programme through good use of skill mix. Allocation of health visitors to teams is linked to deprivation and cases are weighted according to complexity. Ante natal contacts are either through letter or where vulnerabilities are identified then the family will receive a home visit. There has been a recent mapping exercise to ensure that each secondary school has a named senior school nurse and this will be implemented by September 2011.

3.4 Effective liaison between health visiting and school nursing services makes sure that the transfer of young children into the school nursing service are well planned. Transfers of children into school nursing are assessed and where there are additional needs identified, then a face to face handover is arranged. When children are preparing for primary education, school nurses make contact with parents through the school entry health screening questionnaire and offer appointments. Some school nursing teams carry out targeted work with children in the immediate period before they start reception around toilet training, dressing, etc. to help make sure that children are ready for school and where necessary arrange for any additional support. School nurses prepare health plans for any child with an identified need. School nurses offer drop in clinics in most secondary schools and offer advice around health issues, including SRE and maintaining a healthy lifestyle. Attendance at the drop in clinics is variable across the schools.

3.5 Young people have good access to substance misuse services provided by Platform, with high numbers of young people leaving the treatment service in a planned way.

3.6 There is good provision of sex and relationship education. Advice around sex and relationships forms part of a risk reduction model using social norms and is incorporated into the wider agenda around risky sexual behaviours, teen pregnancy and drug and alcohol use. The implementation of the model is new and it is too early to evidence any outcomes. There is a comprehensive training programme being delivered across Middlesbrough with regular roadshows on reducing risk taking behaviours for Year 9 and Year 10 students. Integrated youth support service staff are trained to deliver targeted work to young people who are not in education, employment and training. Additional targeted work takes place with young people with special needs through one to work or small group sessions. The partnership makes good use of local data and has identified localities, schools and colleges where there are high incidences of unplanned conceptions. The local college has just installed a machine to dispense condoms and chlamydia testing kits linked to registration with the C-Card to ensure young people have been assessed as being able to understand and give consent in line with Fraser competencies. Teenage conceptions remain higher than statistical neighbours and the national average, though recent proxy data shows a recent decrease of 2.3% as at December 2010.

3.7 There is good access to Contraception and Sexual Health (CASH) services. CASH and genito-urinary medicine (GUM) services have recently been commissioned from Assura. As with any new service, there have been some minor issues around accessing some services which may have changed their times or appointment systems as part of the new provision. These issues are being resolved as the service becomes embedded across Middlesbrough. The new service combines CASH and GUM giving a comprehensive one stop consultation for young people. CASH services are available six days a week, with emergency contraception available seven days a week. CASH services can fit long acting reversible contraceptives, as can a number of GPs across the district. C-Card is well established across Middlesbrough. There are no gender specific clinics. The PCT have also commissioned a mobile outreach service across Tees to help respond to emerging areas that start to show high conception rates. There is a recognised unmet need for outreach services to help vulnerable young people access CASH services. There are a number of different options being looked at including the ASGARD model which is a service to proactively support vulnerable young people access services to help reduce risk taking behaviours. This pilot is expected to start in September 2011. There is good access to early terminations and the PCT have commissioned post termination contraception and counselling services.

3.8 Highly effective arrangements are in place to safeguard the unborn child. Early booking of pregnancies is encouraged, during which a comprehensive screening for vulnerabilities takes place. There is good recording of fathers' details where this is possible. There is additional support for pregnant women who require additional input from obstetric consultants with special interests around mental health and substance misuse. The South Tees Hospitals NHS FT are working with partners on developing a formal perinatal mental health pathway.

3.9 Midwifery care for pregnant teenagers is through universal services, with a more flexible approach to timing and locations of ante natal visits. There are no dedicated ante natal clinics for teenagers that are pregnant, though referrals can be made to the Baby and Me programme. The community midwives attend the “Baby and Me” course to give advice around the process of birth and pain relief. Teenage parents told us how they had felt stigmatised when attending universal ante natal clinics.

3.10 Satisfactory arrangements are in place for children and young people to access Child and Adolescent Mental Health Services (CAMHS). Referrals to the service are received centrally and assessed by practitioners on a daily basis. Initial appointments are offered for an assessment within four weeks. There can be a further wait of up to 9 weeks for treatment. Access to learning disability CAMHS services follows a similar process.

3.11 There are adequate CAMHS. The TEWV NHS FT offer a range of mental health services across Tiers 2, 3 and 4. All CAMHS practitioners offer a community based service and will visit children and young people in a variety of settings, including the family home. There are well developed care pathways for children and young people with Attention Deficit Hyperactivity Disorder (ADHD), early psychoses and eating disorders. There is an established diagnosis and treatment pathway for children and young people with neurodevelopment disorders both in CAMHS and more recently in learning disability/CAMHS services, which comply with NICE guidance. There is a good learning disability CAMHS service that operates across Teeside. There is good access to a range of respite care provision across Middlesbrough that supports children and families where there are complex health care needs and for children with learning disabilities.

3.12 Satisfactory arrangements are in place to provide Tier 4 CAMHS services. The TEWV NHS FT has a 14 bedded in patient unit that offers care for young people aged 12 up to 18 years. The trust has a policy on only admitting young people to a CAMH facility and if the unit is full, then alternative providers will be sought. Young people are only placed on an adult ward where it is clinically appropriate. The trust has in place suitable arrangements to safeguard a young person placed on an adult ward and every effort is made to transfer them to a CAMH bed as soon as one is available.

3.13 Parents and carers of children with disabilities told us that they often experienced delays in getting a diagnosis for their children who presented as being on the autistic spectrum. They reported that the services available to their child depended on where they were initially referred to and gave specific examples of the differing support between CAMHS and LD CAMHS. Parents also told us that the continence service did not meet their needs; they said that there were long waits to access the service, the products prescribed were insufficient to meet their needs and the quality of the product was poor. An example was given of how a nappy for a child was so thin that it required more frequent changing but the number of nappies prescribed did not allow this and parents had to supplement their prescribed supply with shop bought products.

3.14 Strong and effective relationships across paediatric health teams working on wards and in the community means children and young people with complex health needs receive a co-ordinated approach to their care from familiar staff. Some joint clinics held across specialties take place. These clinics facilitate a comprehensive assessment and treatment plan and often reduce the need for multiple attendances.

3.15 Effective liaison between the paediatric nurses and education helps to ensure that children with complex needs can access recreational and educational opportunities alongside their school friends; practitioners were able to describe how they had helped one young person go on holiday with the rest of the class.

3.16 The practice of admitting children and young people to the adult Section 136 suite as a place of safety and for assessment under Section 136 of the Mental Health Act 2008 is not acceptable. Commissioners told inspectors that they are currently exploring alternatives but as an interim measure if a child or young person was admitted to the suite, CAMH staff are available to provide the care to these very vulnerable children.

3.17 There is good awareness of the need to safeguard children who may have significant contact with an adult mental health service user. TEWV NHS FT reinforces the importance of recording and assessing the impact of the adult service user's mental health on any child in its safeguarding training. The named nurse is working with the PARIS team on developing a system to collect more comprehensive details on children of service users as well as having a flag to identify parents of children who have a child protection plan in place. Good arrangements are in place to safeguard any children visiting parents that are resident in the medium secure unit.

3.18 Arrangements for looked after children and young people to have their health needs identified and met are good. All requests for initial health assessments are checked to ensure appropriate consent has been received. All initial health assessments are carried out by an associate specialist, a staff grade paediatrician or registrar. Outcomes from of the assessments are used to formulate the health plan. The lead clinician for LAC quality assures the assessment and countersigns the health plan. The health plan is then sent to the social worker and copied to the LAC health team, the health visitor or school nurse and the GP. An agreed copy of the plan is also sent to the young person or their carer. Currently, 74% of initial health assessments are carried out within 28 days.

3.19 Good arrangements are in place for looked after children and young people to receive statutory reviews of their health needs. The LAC administrator notifies the health visitor or school nurse, the social worker, the foster carer and the child, depending on their age, of the need to carry out the review health assessment. The health visitor or school nurse carries out the review health assessment and uses this information to update the health plan. The reviews are age appropriate and consider whether the young person requires advice and support around sexual health and contraception and a substance misuse screening tool is also completed. Young people are given a choice of venue for the health assessment and the in-house form has a space to indicate that this has been explained to them. The social worker, GP and LAC nurse are sent copies of the assessment and the health plan, though some GPs reported that they did not always receive these. Health visitors and school nurses receive regular training on conducting LAC health reviews. The overall percentage of LAC registered with a dentist is 91% and overall percentage of immunisation is up to date is 90%, 63% of RHA are in 28 days. The timeliness of the initial health reviews and review health assessments has been of some concern. A recent multi agency meeting identified where improvements could be made and these are now being implemented. There are plans to carry out a further audit to monitor the effectiveness of the changes.

3.20 The arrangements for health review assessments for those children placed out of borough are adequate, though there continues to be problems in receiving a timely response. The designated LAC nurse advises the receiving authority's designated nurse of the need for the health review one month in advance. There are arrangements in place should a receiving authority charge for this service.

3.21 Young people who are looked after have good access to universal services for sexual health, contraception and substance misuse services. The designated LAC nurse or the social worker offers support to a young person in accessing these services if necessary. The designated LAC nurse is C-Card trained and can also offer pregnancy testing and chlamydia testing.

3.22 The use of the strengths and difficulties questionnaire (SDQ) to assess and inform any healthcare planning around the emotional health and wellbeing of LAC is poor. Recently, the LAC health team have started to send out the SDQ to health visitors, school nurses and where appropriate the young person at the same time as the notification of the health review. The SDQ is them completed as part of the review and returned to the social worker. This has improved previous poor completion rates. Completed SDQs are scored by the social worker and where there are any concerns identified, then these are sent to the CAMHS LAC team in batches. There is no agreed process on how the completed SDQs are used to inform a care plan for the young person. The LAC health team do not send out SDQ forms where the young person is placed out of borough; these are sent out by the social worker direct.

3.23 Looked after children and young people currently have good access to a specialist LAC CAMHS team. The LAC CAMHS team offer consultation to professionals working with LAC as well as supporting foster carers to help avoid placement breakdown. However, there is concern that the team are now operating at a significantly reduced capacity which will be further compromised in August 2010 when a further member of the team leaves her post, leaving only one full time specialist practitioner. The commissioning of CAMHS service is under discussion by the partnership, however, a contingency arrangement to ensure that LAC continue to receive an enhanced service either through a specialist team or following an agreed care pathway has not been finalised. The local authority and PCT have given reassurances that resources will be in place to ensure that looked after young people will not be disadvantaged during this period of review and re-commissioning. Any looked after child or young person with learning disabilities is cared for by the core CAMHS/LD team.

3.24 Good support is available to a teenager who is looked after and may conceive. If a young person discloses that they are pregnant then an appointment is made for the young person to discuss their options with a sexual health worker. If they choose to continue with the pregnancy then, with the young person's consent, they are referred to the "Young Mum's To Be" programme and the LAC nurse will contact the health visitor. Midwives also ask if a young person is a care leaver so that they are able to offer an enhanced service if necessary.

3.25 The arrangements for the designated nurse for LAC to influence the health component of the pathway plan are inadequate. Currently the designated nurse for LAC is not involved in the pathway planning process for young people leaving care. This means that the plan may not reflect the most current professional health advice. The arrangements for providing looked after young people with a comprehensive summary of their healthcare when they leave care are inadequate. The designated nurse for LAC is due to meet with the Children in Care Council in June to discuss the format, content and design of a health passport. As an interim measure, young people are provided with a copy of their latest health plan and a letter giving some additional detail.

4 Outcome 6 Co-operating with others

4.1 Good arrangements are in place to care for a young person who attends the A&E following an incident of self harm. If the young person is under 16 then they are admitted to the paediatric ward until medically stable and the following day the young person is assessed by CAMHS prior to discharge. If the young person is between 16 and 18, then depending on the need, they can be admitted to an adult ward and assessed by CAMHS or discharged with a follow up appointment. Advice is available to A&E staff out of hours from the CAMHS Consultant; however, there can be some delay in accessing this. Support is also available from the adult crises team. If a young person over 16 attends the unit following substance misuse, then they are made medically safe and discharged with an appointment for the Primary Alcohol and Drugs Service which is based in the hospital.

4.2 Transition arrangements for young people transferring from CAMHS in to adult mental health services are variable and are dependant upon availability of staff and the locality. There is an effective multi agency transition panel that aims to identify young people with learning disabilities at an age that may require adult services. This means that there is good planning and co-ordination of care into adult services for young people with learning disabilities. Transition nurses employed by TEWV NHS FT ensure that comprehensive health action plans are produced for this vulnerable group of young people.

4.3 There is good information sharing between midwifery staff and children and families team that is supported by a robust "Interagency Safeguarding the Unborn Baby Process". Critical meetings take place at pre determined intervals to ensure that appropriate child protection arrangements are in place for when the baby is born.

4.4 Health visitors and school nurses regularly attend child protection meetings and there is good use of skill mix in carrying out pieces of planned work. However, the input into network meetings for child in need cases is variable, with invitations to initial meetings not always being received from children's social care or health staff not attending where they deem it unnecessary. This means that information may not always be fully shared. This was found to be the case in one of the records examined by the CQC inspector. Family nurses are allocated to families of concern where there is more than one child. The family nurse will carry out any health assessments and takes responsibility for liaison with children and families services via child protection or network meetings. This improves communication with and about families of concern.

4.5 There is some good partnership working between health visitors, school nursing and social workers facilitated by social work teams that are now aligned to localities. Social workers have attended some health visiting and school nursing team meetings and these were reported as being useful.

4.6 The partnership has recently formed a risk management group, with the aim of identifying the small number of young people who are demonstrating high risk behaviours. The aim of the group is to mobilise and prioritise services to ensure that there is an intensive, individualised care package to wrap around the young person to help keep them safe.

4.7 There was good awareness by front line practitioners across all health providers on how to refer any safeguarding or child protection concerns to the local authority's children and families team. Most staff said that social workers responded to their referrals and gave verbal feedback on what action was being taken. Health practitioners we spoke to were clear about the priority given to child protection and safeguarding children and all confirmed that their organisation supported their attendance at child protection meetings. The named nurses across the partnership offered good support to staff in facilitating attendance at child protection and network meetings and in the writing and submission of reports to child protection conferences. The Middlesbrough Children Safeguarding Board's Performance Management Sub Group monitors attendance at child protection meetings to maintain good involvement and attendance by all partners.

4.8 There was good awareness across health partners on the impact of domestic violence on children in the family. Health agencies are appropriately represented on the MARAC. However, health visitors and school nurses are not routinely made aware of when police have visited a family following an incident of domestic violence. This means that they may not be able to make a comprehensive assessment on the needs of a family.

4.9 There were mixed experiences in primary care around the sharing of information of children who had child protection plans in place and looked after children. Some GPs reported that they did not routinely receive copies of the initial health assessment or review health assessments of children who were looked after and registered at their practice. Some GP practices said that they did not regularly receive timely notification of children who had child protection plans in place. The failure to share information was evident in one of the files inspected by CQC as part of this inspection

5 Outcome 7 Safeguarding

5.1 The arrangements for the designated professionals for Middlesbrough PCT are adequate. The designated nurse is employed full time and covers four primary care trusts that form NHS North Tees. Up until recently there was a further full time assistant designated nurse, however, this post is now vacant and it is unclear whether the post will be recruited to. As an interim measure, the designated nurse is supported by approximately two trainers who are able to offer up to one and a half day's time between them, per week. The line management arrangements for the designated professionals are in line with Working Together 2010. The designated doctor for Middlesbrough also covers a different PCT and he is allocated two sessions a week across the two PCTs. The team have access to good administrative support.

5.2 There is good input of the designated nurse into commissioning services. NHS North Tees now routinely include comprehensive safeguarding standards in the commissioning of all services.

5.3 Very good progress has been made in supporting general practitioners in meeting their responsibilities under "Working Together 2010. 78% of GPs in Middlesbrough have now received appropriate safeguarding children training. Safeguarding training is also part of the formal GP appraisal process and where this cannot be evidenced, then it will form part of the personal development plan. The designated professionals have carried out a large number of GP practice visits to offer advice and support and this continues to be much appreciated. The designated nurse carries out a quarterly audit of GP reports to conference and there is good progress being made, with 78% of all child protection conferences now including a report from primary care which is a significant improvement. Individual GP feedback and Practice feedback is given on all received reports and where a report has not been received. GP practices have identified leads for safeguarding children and the PCT has hosted two safeguarding leads meetings; these have been instrumental in increasing awareness around safeguarding children and the numbers of GP practices contacting the designated and named professionals for advice and guidance continues to increase. The NHS North Tees continues to promote and support dentists and optometrists with meeting their commitment to safeguarding children training. Each dental practice is Middlesbrough has at least one member of staff that has attended safeguarding children training. The PCT and representatives from the dental community are exploring how the fluoridation programme may link into the safeguarding children agenda by identifying possible neglect.

5.4 The practitioners attending the focus group for GPs and primary care were positive about the PCTs programme of visits to GP practices and described how this, combined with safeguarding children training, had led to improvements in safeguarding children practice. All the practices represented at the focus group had up to date policies and procedures for safeguarding children based on the template provided by the PCT. One GP told of how, following the safeguarding training, her practice had proactively identified children and families where there were child protection plans in place, where there were children in need as well as children who were chronically ill and planned to discuss the cases on a quarterly visit with their nominated health visitor. Although this meeting had not taken place at the time of inspection it was evident that significant planning had taken place and that the co-ordination and sharing of information about vulnerable children would be enhanced.

5.5 The designated nurse for LAC is employed full time and is co-located with Middlesbrough's Leaving Care Team. The lead clinician for LAC is also the PCTs medical advisor for fostering and adoption as well as providing training and advice to colleagues. The lead clinician advised that NHS North Tees were in the process of formalising the role. There was a period over the past 18 months when the team had been operating with significantly reduced administrative support and this, in part, contributed to the delay in processing the initial health assessments and health reviews for LAC. Additional administrative support has now been secured. The designated LAC nurse has full access to Middlesbrough's children and families service database and the facility to use secure email between the two teams to confidentially share information is imminent.

5.6 There is good involvement of the designated nurse for LAC in the training of potential and existing foster carers which helps to ensure that the health of LAC remains a priority. She also visits the residential homes on a monthly basis to support staff in delivering health promotion advice and guidance to the young people.

5.7 There is good capacity within the named professionals team in South Tees Hospitals NHS FT. There are 2WTE named nurses to provide advice, support and training to acute and community services as well as an additional 2WTE specialist child protection nurses, 0.6WTE trainer and one specialist midwife safeguarding children full time post is currently being recruited to. There are two named doctors for the trust, each has one session allocated to the role. The trust has identified an anaesthetist to carry out the role of lead anaesthetist for child protection/safeguarding and are in the process of finalising the arrangements. The named professionals are well supported by an administrator. The line management and supervision arrangements for the named professionals are satisfactory. There is good oversight on referrals from midwifery to children and families team by the safeguarding team at South Tees Hospitals NHS FT. This helps to ensure that good multi agency arrangements are in place when the baby is born.

5.8 Adequate arrangements are in place for the named safeguarding children professionals in TEWV NHS FT to fulfil the requirements of Working Together 2010. The named nurse is supported by 1.5WTE senior child protection nurses and there is approval to recruit an additional full time post to the team. The safeguarding team also includes a full time First Contact trainer and there are plans to recruit additional administrative support. The named doctor continues to have one session per week though she is now supported by an additional doctor who is also working one session per week. It is anticipated that this additional resource will enable more targeted safeguarding children training of medical trainees and adult psychiatrists. The work of the children safeguarding team is supported by a network of safeguarding children link staff. The link staff meet bi monthly and there is a job description for the role, which includes dissemination of information and providing first line advice to front line practitioners.

5.9 The South Tees Hospitals NHS FT have developed an effective policy on responding to children and young people who do not attend clinical appointments. The policy requires clinicians to identify the potential outcome of the child or young person not attending the appointment in the letter to the GP and health visitor, school nurse or social worker. This allows professionals to assess the risk and respond accordingly. The policy has been initially launched in paediatrics and now requires implementation across the trust.

5.10 The arrangements to identify and safeguard children and young people who do not attend their CAMHS appointments are being reviewed by the TEWV NHS FT. The revised DNA policy is being considered by TEWV NHS FT and this requires ratification and implementation before any audit on compliance can be carried out.

5.11 Adequate arrangements are in place for the examination of children and young people following allegations of sexual abuse. Children and young people who require a specialist forensic examination following allegations of acute sexual abuse travel to Newcastle for an examination in a purpose built suite. The paediatrician who carries out the examinations of historic abuse is due to retire soon and there are concerns about continuity of the service.

5.12 There is an effective Child Death Overview Panel for Middlesbrough that is part of a Tees wide arrangement covering four local authorities. It is appropriately constituted and has influenced change to practice Tees wide.

6 Outcome 13 Staffing numbers

6.1 Insufficient numbers of paediatric nurses within the A&E at James Cook University Hospital means that A&E are unable to roster a nurse with paediatric qualifications for each shift. To mitigate the risk, the A&E trainer has taken the Maximising Skills for A&E Staff publication and used this to compile a set of competencies around care of children and young people in an emergency setting. Where paediatric training is an identified need, this is being delivered against the competencies. This work is at a very early stage. The A&E does have access to staff working in the paediatric intensive care unit if specialist nursing skills are required.

7 Outcome 14 Staffing support

7.1 The South Tees Hospitals NHS FT are making progress in addressing the deficit in training staff in safeguarding children. There is a recovery plan and the trust aim to have all staff trained to an appropriate level by March 2012. Good learning opportunities are in place within the A&E to provide ongoing education around safeguarding children practice. As well as mandatory safeguarding children training, regular quarterly paediatric and A&E meetings take place at which safeguarding is discussed, including identification of good practice and exploring where lessons can be learnt. In addition there is a yearly paediatric study day which contains reference to safeguarding children

7.2 The South Tees Hospitals NHS FT have developed a supervision policy that aligns the supervision of a case where there is either a child protection plan or a child in need plan to key meetings to allow the supervisor and supervisee to prepare for the meeting and to explore the input and case management for that family and child. Feedback from front line practitioners on the revised supervision timetable has been positive. However, concerns have been raised that the frequency of supervision in the new policy is insufficient to provide ongoing robust challenge to front line practitioners and that the new policy has been developed and at the time of the report did not have the approval of the designated nurse or Middlesbrough Safeguarding Children Board.

7.3 It is concerning that community health staff working in the prescribing adult substance misuse service no longer have access to timetabled child safeguarding supervision. This group of staff work with intensively with adult service users and would benefit from regular child safeguarding supervision to ensure that the needs of any child in the family were being identified and addressed.

7.4 Take up of training in safeguarding children within the TEWV NHS FT is improving though still inadequate. 64% of staff have received level 1 training, 42% have received level 2 training and 52% of appropriate staff have received level 3 training. There are now improved reporting systems in place to identify compliance across directorates and these are considered by the trust board. The named nurse advised that there has been increased attendance and bookings for safeguarding training and is hopeful that this trend will continue. There are adequate arrangements in place for front line practitioners to receive safeguarding children supervision.

8 Outcome 16 Audit and monitoring

8.1 NHS North Tees is a committee of the boards of primary care trusts for Hartlepool, Stockton on Tees, Redcar and Cleveland and Middlesbrough. NHS North Tees is well established and continues to have good board assurance and governance arrangements for safeguarding children. There is appropriate representation on the Children's Trust Board and the Middlesbrough LSCB. The designated nurse has delegated responsibility to represent the PCT on the LSCB. NHS Tees are in the early stages of including safeguarding children indicators as part of the formal reporting procedures considered at the clinical quality review group. This will ensure that any provider who is not compliant with local safeguarding children protocols will be held accountable.

8.2 The South Tees Hospitals NHS FT have good board assurance and governance arrangements for safeguarding children. The trust is represented on the Middlesbrough LSCB. The assistant director of nursing and the named nurse for safeguarding children have attended trust board of directors' event to carry out training in safeguarding children and to present key issues that have arisen, both locally and nationally. The key risks around numbers of staff attending safeguarding children training and nursing staff in A&E obtaining key competencies in caring for babies, children and young people have been included in the trust's risk register and there are action plans in place to ensure compliance by March 2012.

8.3 The South Tees Hospitals NHS FT make good use of audit to monitor compliance with safeguarding children policies and procedures. Recent audits on management of accidental overdose of medication led to fewer inappropriate referrals to children and families services. A second audit on recognition of extremes of nutritional state in paediatric outpatients led to a more targeted approach in growth monitoring of children and young people which avoids unnecessary use of resources as well as relieving anxiety in families.

8.4 Adequate governance arrangements and board assurance is in place for safeguarding children within the TEWV NHS FT. The trust board receive the annual report for safeguarding children and the named safeguarding professionals are scheduled to attend a trust board session on Safeguarding Children. Quarterly reports on safeguarding children are presented to the Quality Assurance Committee which is a formal sub committee of the trust board and chaired by a non executive director. The trust is represented on the Middlesbrough Children Safeguarding Board.

9 Recommendations

Within 3 months (from report)

Ensure all partner agencies provide robust safeguarding supervision for staff and that firm arrangements are in place for the MSCB to agree and monitor compliance with supervision policies. (Ofsted 2011)

Ensure all key partners including health visitors and school nursing staff are fully informed about domestic violence incidents where children or young people are present in the household. (Ofsted 2011)

Ensure information obtained from the strengths and difficulties questionnaires is used effectively to influence the emotional health and wellbeing of looked after children. (Ofsted 2011)

Ensure that the emotional health and wellbeing of looked after children is not compromised throughout the period of review and recommissioning of the looked after children CAMHS. (Ofsted 2011)

Within 6 months

Ensure all looked after children receive timely health assessments and health reviews and that care leavers receive a comprehensive summary of their health care when they leave care (Ofsted 2011)

Review the continence service to ensure it meets the needs of the children and families.

Next steps

An action plan is required from the commissioning PCT within 20 working days of receipt of this report. Please submit the action plan to your SHA copied to CQC through childrens-services-inspection@cqc.org.uk and it will be followed up through the regional team.